Request for Access to McClears

❑ New Request	❑ Change/Renewal	❑ Termination of Access

McClears ID (for Change/Renewal or Termination only) _____

Employee Name_____

Title_____ Department_____

Job Function_____

Medical Service Provider/Facility Name _____

Facility address_____

_____

Phone number _____Email address_____

This Facility is:

❑ Clinic	❑ Hospital	❑ Pharmacy	❑ Billing Service	❑ Specialty Care Provider

As a medical service provider to qualified recipients of Milwaukee County's General Assistance-Medical Program (GA-MP), do hereby confirm and swear to the following:

1. I understand that access to the information contained in the GA-MP recipient/eligibility database has been granted to me by the county as recommended by my employer for the purpose of assisting the County and/or my employer in the administration of the program.
2. I have read, or have had read to me, the following provision of Wisconsin State Statue regarding the release of any information contained in the GAMP database:

   49.83 Limitation on giving information. Except as provided under s. 49.32 (9), (10) and (10m), no person may use or disclose information concerning applicants and recipients of relief funded by a relief block grant, aid to families with dependent children, Wisconsin works under ss. 49.141 to 49.161, social services, child and spousal support and establishment of paternity services under s. 49.22 or supplemental payments under s 49.77 for any purpose not connected with the administration of the programs. Any persons violating this section may be fined not less than $25.00 and not more than $500.00 or imprisoned in the county jail not less than 10 days nor more than one year or both.
3. I understand that disclosure of any information contained in the GA-MP database in either written, electronic or oral form may subject me and my employer to criminal and/or civil legal actions as stated in section 2 of this agreement and the access to the GA-MP database will be permanently revoked at any time by the County whenever the County has determined it necessary to preserve the confidentiality of its clients.
4. I agree to adhere to all County policies and procedures regarding access and use of the GA-MP database.

Signature_____ Date_____

Supervisor Approval

I confirm that the above named person is an employee of my facility and that his/her job duties require access to the GA-MP database. I further acknowledge that this employee has been made aware of and understands all access requirements and the regulations regarding the use of this information.

I am requesting this employee have access to the following screens:

- ❑ GA-MP Eligibility
- ❑ Utilization Management

Supervisor Name_____ Phone Number_____

Supervisor Signature_____Date_____